PHILIPS

Point of care ultrasound (pocus)

2023 coding and medicare national payment guide

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POINT OF CARE ULTRASOUND

The term point-of-care ultrasound (POCUS) refers to portable ultrasound systems that allow the assessment of patients without requiring them to be physically present in a radiology department.[1]

Ultrasound services performed with an Ultra mobile or hand-carried ultrasound system are reported using the same ultrasound codes that are submitted for studies performed with cart-based ultrasound systems so long as all applicable requirements for that code are met. For example, all ultrasound examinations must meet the requirements of medical necessity as set forth by the payer, must meet the requirements of completeness for the code that is chosen, and must be documented in the patient's record, regardless of the type of ultrasound equipment that is used.

Documentation Requirements[2,3,4]

- **Diagnostic ultrasound** examinations require permanently recorded images with measurements when clinically indicated. For those anatomic regions that have "complete and "limited" ultrasound code descriptors, note the elements that comprise a complete exam. The report should contain a description of these elements or the reason that an element could not be visualized (eg obscured by bowel gas, surgically absent, etc.). If less than the required elements for a complete exam are reported, the "limited" code for that anatomic region should be used once per patient exam.
- **Ultrasound guidance procedures** require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for the which the guidance is utilized. When performing procedures that require needle placement, it is not necessary to capture an image of the needle in the relevant anatomy, as this distraction may pose a risk to the patient at a critical point in the procedure. It is sufficient to capture an image of the relevant point of interest. The procedure note should reflect the needle was guided and visualized under ultrasound.

Three documentation components are required for reimbursement: 1) medical necessity; 2) a written interpretation; and 3) image capture and storage.

1. Medical Necessity

Medical necessity is usually determined by the payer via coverage policies, care guidelines, preauthorization, etc. The medical necessity or indications for the procedure must be clearly stated and meet the diagnosis code requirements outlined by the payer

2. Written Interpretation

As the clinical ultrasound exam is immediately interpreted, the findings should be immediately communicated to other providers and consultants by a separate written report and interpretation maintained in the patient's medical record. The report should include:

- Date and time of examination
- Name and hospital identification number of the patient

- Patient age, date of birth, and sex
- Name of the person who performed and/or interpreted the study, clinical findings
- Indication for the study, the scope (complete vs limited), and if this is a repeat study by the same provider, repeat by a different provider, or reduced level of service
- Impression (including when a study is nondiagnostic) and differential diagnosis, as well as the need for follow on exams and incidental findings
- Mode of archiving the data (where can the images be found to be viewed)

3. Image Capture

- All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, should have the orienting anatomy labeled and must have permanently recorded images maintained in the patient record.
- The stored images do not need to be submitted with the claim; however documentation of the study must be available to the insurer upon request. Images can be stored as printed images, or digital images.
- Timely documentation and image capture and recording will also facilitate peer review and quality analysis.
- The CPT code does not require a certain number of images but does require that the images captured reflect the reported finding(s). Medicare payer policy regarding image retention requirements vary significantly by regional carrier. Some carriers have no published policies; others require only that the study indication or the physician report appear in the medical record; some carriers require that images be available for review upon request. Consult local and national coverage policies and requirements for each payer.

CPT Coding[3]

POCUS procedures are reported using Current Procedural Terminology, 4th Edition (CPT-4) codes with payment rates assigned to each code. The CPT codes include very specific requirements for reporting and documenting both diagnostic ultrasound examinations and ultrasound guidance procedures. Providers are cautioned to review these requirements prior to billing for procedures performed using any ultrasound system.

Modifiers

Modifiers are used to describe a modification to the procedure performed without changing the definition of the code. More than one modifier can be used per CPT code. The modifier essentially "splits the bill" and adds information so the payor can better understand the events and circumstances of the visit.

- **Reduced Services -52:** Under certain circumstances a service is partially reduced or eliminated at the providers discretion. The usual CPT code is used with the added -52 modifier indicating that the typical procedure was not performed as described, but rather at some reduced level of service.
- **Distinct Procedural Service -59:** This modifier is used to report procedures that are distinct but have the same CPT code. For example, if a patient had multiple foreign bodies in both the

right upper and lower extremities, the 76881 complete or 76882 limited as appropriate code for ultrasound extremity, nonvascular, real time with image documentation, would be used twice, with a -59 modifier.

- In the case of procedures performed in a hospital or ASC (facility setting) the physician bills for the professional component (-PC), and the hospital bills for the facility overhead, equipment and staff time as facility services.
    - **Professional Component -26:** This modifier is reported by the provider for interpreting the examination and preparing a separate complete written report. The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional.
    - **Technical Component -TC:** The technical component (-TC) represents the cost of the equipment, supplies and personnel to perform the procedure.
    - **Global:** Payments for ultrasound procedures performed in a non-facility setting (eg, physician office) are comprised of both a professional component (-26) and a technical component (-TC). The professional component represents physician work only and the technical component represents facility overhead, including equipment costs, and staff time. **The combination of the professional and technical component is referred to as the "global" payment.** The "global" service is identified by reporting the CPT code by itself, *without* modifier -26 or -TC

Not all CPT codes break out into a professional/technical component, instead some are paid based on "facility" vs "non facility" setting. In those cases, higher reimbursement is made to the physician for services performed in the "non facility" or office based setting. This additional payment is designed to account for costs incurred in this site of service that are not setting incurred by the physician in the "facility" setting (hospital or ASC), such as rent, salaries, supplies, etc. These payment rates are indicated in the physician "professional" (facility) and "global" (non facility) payment columns in the next Coding and Payment section of this Guide.

HIGHLIGHTS[2,11,12,13]

Device Ownership – Billing Implications

- Ownership of the device impacts the type of billing allowed. Hospital device ownership is preferable, allowing billing for both facility and professional fees. It is unlikely that the facility fee can be billed for devices owned by individuals or physician groups. Without approval from hospital administration, IT, security, and legal departments, it is the stance of the American College of Emergency Physicians (ACEP) that personally owned devices should not be used clinically.[14] Overall, it is recommended that the hospital purchase both the HHU transducer and the device with which it will be used as this will allow for both the professional and technical fees to be charged without changes to extant billing structures.

Complete Versus Limited Ultrasound Examination

- CPT codes often distinguish between complete and limited studies. Ultrasound examinations are considered "complete" studies unless specified as "limited" in their code definitions. A complete study is one in which an attempt is made to visualize and diagnostically evaluate all the major structures within the anatomic description.
- If less than the required elements for a "complete" exam are reported (e.g. limited number of organs or limited portion of region evaluated), the "limited" code for that anatomic region should be used. If a limited examination is performed and a clinical finding is encountered which necessitates a complete exam, then the complete study may be performed and billed.
- When there is a choice to code for a limited or for a complete study, ultrasound used in a "focused," way most often will be appropriately coded as a limited study, as its indication was to answer a specific clinical question in a particular region or area of the body. Some situations may require several limited studies (such as FAST exam) which may be billed individually.
- In situations where there is no available CPT code for a limited ultrasound exam, facilities and providers should report the complete ultrasound study with modifier -52 (reduced service).

Capturing/Storing images Complete Versus Limited Ultrasound Examination

- All ultrasound examinations, including ultrasound procedure guidance, require that permanently recorded images be maintained. The images may be maintained in the patient record or some other archive and may not need to be submitted with the claim. Documentation of the study must be available to the payer if requested. Images can be stored on a digital medium or as printed images.
- A written report of all ultrasound studies should be maintained in the patient record. The written report for ultrasound guidance studies may be filed as a separate item in the patient record. These guidance procedures also require permanent recording of the site to be localized as well as a documented description of the localization process, within the report, or separately, of the procedure where guidance is utilized.

Professional/Technical

- The CPT codes for POCUS account for both a professional and a technical component. The professional component covers the clinician's services performing, interpreting, and reporting the procedure. The technical component represents the cost of the equipment, supplies, and ancillary personnel for performing the procedure.
- When the clinician does not own the machine, modifier -26 (professional component only) must be appended to the CPT code. Clinicians who do not own the machines they are using are not entitled to reimbursement for the technical component of the code, which may be billed by the hospital using modifier -TC.
- Some hospitalists may own their own handheld ultrasound device or mobile machine, in which case the POCUS code may be submitted without a modifier and will be eligible for full payment.

Diagnostic and Procedural Ultrasound Performed by PA/NPs

- Nearly all payers, including Medicare and Medicaid, cover medical and surgical services provided by Advanced Practice Provider (APPs), in accordance with state law. The services are submitted/billed under the name of the APP or under the name of the physician depending on payer policy. It is essential to verify each payer's specific payment and coverage policy for APPs.
- Medicare pays the PA's employer for medical and surgical services provided by PAs in all settings at 85% of the physician fee schedule. These settings include hospitals (inpatient, outpatient, operating room, and emergency departments), nursing facilities, offices, clinics, the patient's home and for first assisting at surgery.
- Commercial insurers do not necessarily follow Medicare policies regarding reimbursement amounts and coverage rules but are similar to Medicare in that services are billed either under the PA's name or the collaborating physician's name. Always obtain local payer requirements to ensure proper billing.

Requirements for Billing Ultrasound for Placing Central Lines

- CPT code +76937 (*Ultrasonic guidance for vascular access requiring ultrasound eval of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, w perm recording and reporting*) is an add-on code used specifically in conjunction with a primary procedure for central venous access with ultrasound guidance. This CPT code is intended for use only when the ultrasound is used with the "dynamic" technique, as opposed to the "static" technique which is not considered a reimbursable service.
    - The static technique utilizes the ultrasound to identify the vessel but is not used during line placement. In the dynamic technique the clinician uses the ultrasound throughout the procedure from initial identification of the vessel through direct visualization of the needle entering the vessel. A permanently recorded image is required for coding.
    - The CPT description is interpreted as requiring an image of the target vessel, but not necessarily an image of the needle in the vessel as it is entering. It is believed that

obtaining an image of the needle as it is entering the vessel poses unacceptable risks to the patient as it would require the solo operator to take his or her attention away from the procedure in order to obtain an image.

- It is recommended that permanent recording of the selected vessel or of the needle entering the vessel when it is feasible and safe, while using a procedure note to document the procedure was performed with concurrent real-time visualization. While a still image of the target vessel prior to successful cannulation is acceptable, a post-procedural still image of the catheter in the vessel, once the line is secure, is preferable.

Medicare 2023 Coding and Payment Guide Point-of-Care Ultrasound (POCUS)

ICD-10 Diagnosis and Hospital Inpatient Codes

For a list of ICD-10 diagnosis and procedure codes, please refer to the ICD-10-CM and PCS 2023: The Complete Official Codebook for coding options.

Medicare 2023 Average Hospital Outpatient, ASC, and Physician Payment

Medicare 2023 hospital outpatient and ambulatory surgery center (ASC) services are based on Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2023 Final Rule Correction Notice, OPPS Addendum B and ASC Final Addenda. Physician payment is made separate from hospital outpatient payment. Physician payment reflected in this guide is based on 2023 Medicare Physician Fee Schedule as outlined in the Calendar Year 2023, Addendum B, using MPFS 2023 conversion factor 33.8872.

		2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
Code[5]	Descriptor	Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023 Payment
1	**CORE EMERGENCY ULTRASOUND CODES** *https://www.acep.org/administration/reimbursement/reimbursement-faqs/ultrasound-faqs/#question8*						
Trauma / FAST Exam (Cardiac, Lung, Abdomen)							
76604	Ultrasound, chest (includes mediastinum), real time w image documentation	$28	$30	$58	5522 / Q1	$107	Pkgd
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	$28	$61	$90	5522 / Q3	$107	$56
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	$25	$75	$100	5523 / S	$234	Not payable
Procedural Guidance							
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	$60	NA	$101	5441 / T	$272	$57
49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	$106	NA	$300	5301 / T	$826	$430
+76937	Ultrasonic guidance for vascular access requiring ultrasound eval of potential access sites, documentation of selected vessel patency, concurrent real time ultrsnd visualization of vascular needle entry, w permanent recording and reporting	$14	$26	$40	N	Pkgd	Pkgd
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$30	$28	$59	N	Pkd	Pkgd
Common ER Point of Care Ultrasound							
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	$30	$18	$48	5522 / Q1	$107	Pkgd
76604	Ultrasound, chest (includes mediastinum), real time w image documentation	$28	$30	$58	5522 / Q1	$107	Pkgd
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	$28	$61	$90	5522 / Q3	$107	$56
76775	Ultrasound retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$28	$32	$60	5522 / Q1	$107	Pkgd
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	$32	$52	$83	5522 / Q1	$107	Pkgd
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	$36	$58	$95	5522 / Q1	$107	Pkgd
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	$25	$75	$100	5523 / S	$234	Not payable
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	$21	$100	$121	5522 / S	$107	Not payable

ULTRASOUND PROCEDUREAL GUIDANCE - ABDOMEN - BREAST

Code[5]	Descriptor	2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
		Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023 Payment
2	**ULTRASOUND PROCEDURAL GUIDANCE**						
76932	Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation	$36	$0	$0	N	Pkgd	Pkgd
+76937	Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, with permanent recording and reporting	$14	$26	$40	N	Pkgd	Pkgd
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	$100	$0	$0	N	Pkgd	Pkgd
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$30	$28	$59	N	Pkgd	Pkgd
76998	Ultrasonic guidance, intraoperative	$61	$0	$0	N	Pkgd	Pkgd
3	**ABDOMEN**						
49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	$106	NA	$300	5301 / T	$826	$430
49084	Peritoneal lavage, including imaging guidance, when performed	$108	NA	NA	5301 / T	$826	$430
76705	Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	$28	$61	$90	5522 / Q3	$107	$56
76706	Ultrasound, real time with image documentation; for abdominal aortic aneurysm (AAA) screening.	$26	$82	$109	5522 / S	$107	Not payable
76775	Ultrasound retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$28	$32	$60	5522 / Q1	$107	Pkgd
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; limited study	$38	$123	$161	5522 / S	$107	Not payable
4	**BREAST**						
19083	Biopsy, breast, with placement of breast localization device(s) when performed and imaging of biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	$154	NA	$514	5072 /J1	$1,500	$637
+19084	; each additional lesion	$78	NA	$393	N	Pkgd	Pkgd
19285	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance	$85	NA	$381	5071 / Q1	$649	Pkgd
+19286	; each additional lesion	$43	NA	$312	N	Pkgd	Pkgd
76642	Ultrasound, breast unilateral, real time with image documentation including axilla when performed; limited	$33	$54	$87	5521 / Q1	$87	Pkgd

CARDIAC ULTRASOUND - ELASTOGRAPHY - ENDOCRINE

Code[5]	Descriptor	2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
		Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023 Payment
5	**CARDIAC ULTRASOUND**						
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	$36	$122	$158	5524 / S	$503	Not payable
93306	Echocardiography, transthoracic, real time with image documentation (2D) inc M-mode recording when performed; complete, with spectral Doppler and color flow Doppler	$68	$130	$199	5524 / S	$503	
93307	Echocardiography, transthoracic, real time with image documentation (2D) inc M-mode recording when performed; complete, without spectral Doppler or color flow Doppler	$43	$95	$139	5523 / S	$234	
93308	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; follow-up or limited study	$25	$75	$100	5523 / S	$234	
93312	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; inc probe placement, image acquisition, interpretation and report	$106	$134	$239	5524 / S	$503	
93313	Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	$11	NA	NA	5524 / S	$503	
93314	Echocardiography, transesophageal, real time with image documentation (2D) with or w/o M-mode recording; image acquisition, interpretation and report only	$89	$142	$231	N	Pkgd	
+93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow- up or limited study	$7	$18	$25	N	Pkgd	
+93325	Doppler echocardiography color flow velocity mapping	$3	$21	$24	N	Pkgd	
6	**ELASTOGRAPHY**						
76981	Ultrasound, elastography; parenchyma (eg, organ)	$29	$77	$106	5522 / Q3	$107	$56
76982	Ultrasound, elastography; first target lesion	$29	$66	$95	5522 / Q3	$107	$56
+76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	$25	$37	$62	N	Pkgd	Pkgd
7	**ENDOCRINE**						
60300	Aspiration and/or injection, thyroid cyst	$48	NA	$109	5071 / T	$649	$71
76536	Ultrasound, soft tissues of head and neck (e.g. thyroid, parathyroid, parotid), real time with image documentation	$27	$86	$114	5522 / Q1	$107	Pkgd
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$30	$28	$59	N	Pkgd	Pkgd

FETAL TESTING - MUSCULOSKETAL/SOFT TISSUE

Code[5]	Descriptor	2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
		Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023 Payment
8	**FETAL TESTING / TREATMENT**						
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasoung guidance)	$180	NA	NA	5412 / T	$292	$152
59070	Transabdominal amnioinfusion, inc ultrasound guidance	$312	NA	$406	5412 / T	$292	$152
59072	Fetal umbilical cord occlusion, including ultrasound guidance	$527	NA	NA	5412 / T	$292	$209
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	$312	NA	$390	5412 / T	$292	$152
59076	Fetal shunt placement, including ultrasound guidance	$527	NA	NA	5412 / T	$292	$152
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	$64	$0	$0	N	Pkgd	Pkgd
9	**MUSCULOSKELETAL / SOFT TISSUE**						
20526	Injection, therapeutic (eg local anesthetic, corticosteroid), carpal tunnel	$58	NA	$83	5441 / T	$272	$44
20527	Injection, enzyme (eg collagenase) palmar fascial cord	$66	NA	$89	5441 / T	$272	$48
20550	Injection(s) single tendon sheath, or ligament, aponeurosis (eg plantar "fascia")	$39	NA	$59	5441 / T	$272	$29
20551	Ultrasound, complete joint (ie, joint space and periarticular soft tissue structure(s)) real-time with image documentation	$39	NA	$59	5441 / T	$272	$29
20552	Injection(s), single to multiple trigger point(s) 1 or 2 muscle(s)	$37	NA	$54	5441 / T	$272	$28
20553	…. three or more muscle(s)	$43	NA	$62	5441 / T	$272	$32
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	$46	NA	$83	5441 / T	$272	$49
20606	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) with ultrasound guidance, with permanent recording and reporting	$52	NA	$90	5442 / T	$644	$51
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	$60	NA	$101	5441 / T	$272	$57
20612	Aspiration and/or injection of ganglion(s) cyst any location	$41	NA	$65	5441 / T	$272	$37
76881	Ultrasound, complete joint (ie, joint space and periarticular soft tissue structure(s)) real-time with image documentation	$43	$11	$55	5522 / S	$107	$21
76882	Ultrasound, limited, joint or other focal evaluation of other nonvascular extremity structure(s) (eg, joint space, periarticular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	$33	$9	$43	5522 / Q1	$107	Pkgd
76883	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, incldng real-time cine imaging w image docmntn, per extremity	$58	$15	$73	5522 / Q1	$107	Not Payable
+76937	Ultrasonic guidance for vascular access requiring ultrasound eval of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, w permanent recording & reporting	$14	$26	$40	N	Pkgd	Pkgd
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration), imaging supervision and interpretation	$30	$28	$59	N	Pkgd	Pkgd

OBSTETRIC / PELVIC - OPHTHALMOLOGY

Code[5]	Descriptor	2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
		Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023 Payment
10	**OBSTETRIC / PELVIC**						
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	$180	NA	NA	5412 / T	$292	$152
76801	Ultrasound, pregnant uterus, real time w image documentation, fetal and maternal eval, first trimester (<14 weeks O days), trans abd approach; single or first gestation	$47	$73	$120	5522 / S	$107	$56
+76802	; each additional gestation (List separately in addition to code for primary procedure)	$40	$22	$62	N	Pkgd	Pkgd
76805	Ultrasound, pregnant uterus, real time w image documentation, fetal and maternal eval, after first trimester (> or = 14 weeks, 0 days), trans abd approach; single or first gestation	$48	$90	$138	5522 / S	$107	$56
+76810	; each additional gestation (List separately in addition to code for primary procedure)	$47	$42	$90	N	Pkgd	Pkgd
76811	Ultrasound, pregnant uterus, real time w image documentation, fetal and maternal eval plus detailed fetal anatomic examination, trans abd approach; single or first gestation	$91	$88	$179	5523 / S	$234	$84
+76812	; each additional gestation (List separately in addition to code for primary procedure)	$85	$110	$195	N	Pkgd	Pkgd
76813	Ultrasound, pregnant uterus, real time w image documentation, first trimester fetal nuchal translucency measurement, trans abd or transvaginal approach; single or first gestation	$57	$62	$119	5522 / Q1	$107	Pkgd
+76814	; each additional gestation (List separately in addition to code for primary procedure.)	$47	$29	$76	N	Pkgd	Pkgd
76815	Ultrasound, pregnant uterus, real time with image documentation, limited, one or more fetuses	$32	$52	$83	5522 / Q1	$107	Pkgd
76816	Ultrasound, pregnant uterus, real time w image documentation, FU (e.g., reval of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected/confirmed to be abnormal on a previous scan), transabd approach, per fetus	$41	$71	$111	5522 / Q1	$107	Pkgd
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	$36	$58	$95	5522 / Q1	$107	Pkgd
76820	Doppler velocimetry, fetal, umbilical artery	$24	$22	$45	5522 / Q1	$107	Pkgd
76830	Ultrasound, transvaginal	$34	$89	$122	5522 / S	$107	$56
76857	Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (e.g., for follicles)	$24	$26	$49	5522 / Q3	$107	$25
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	$32	$0	$0	N	Pkgd	Pkgd
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	$18	$15	$33	N	Pkgd	Pkgd
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	$32	$50	$82	N	Pkgd	Pkgd
11	**OPHTHALMOLOGY**						
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	$30	$18	$48	5522 / Q1	$107	Pkgd

PULMONARY - REGIONAL ANESTHESIA/PAIN MANAGEMENT

Code[5]	Descriptor	2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
		Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023 Payment
12	**PULMONARY**						
32555	Thoracentesis, needle or catheter, aspiration of the pleural space, with image guidance	$109	NA	$322	5181 / T	$579	$301
32557	Pleural drainage, percutaneous, with insertion of indwelling catheter, with image guidance	$148	NA	$680	5182 / J1	$1,488	$583
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	$28	$30	$58	5522 / Q1	$107	Pkgd
13	**REGIONAL ANESTHESIA/PAIN MANAGEMENT**						
64405	Injection, anesthetic agent; greater occipital nerve	$53	NA	$76	5441 / T	$272	$36
64415	Injection, anesthetic agent; brachial plexus, single	$69	NA	$137	5443 / T	$852	$444
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infsn by catheter (inc catheter placement)	$78	NA	NA	5443 / T	$852	$444
64417	Injection, anesthetic agent; axillary nerve	$63	NA	$162	5443 / T	$852	$444
64418	Injection, anesthetic agent; suprascapular nerve	$56	NA	$88	5442 / T	$644	$46
64420	Injection, anesthetic agent; intercostal nerve, single	$59	NA	$99	5442 / T	$644	$336
64421	; intercostal nerves, multiple, regional block	$24	NA	$33	5443 / T	$852	$444
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	$55	NA	$112	5442 / T	$644	$73
64445	Injection, anesthetic agent; sciatic nerve, single	$74	NA	$163	5442 / T	$644	$108
64446	Nerve block injection, sciatic continuous infusion	$77	NA	NA	5443 / T	$852	$444
64447	Injection, anesthetic agent; femoral nerve, single	$63	NA	$118	5442 / T	$644	$67
64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	$72	NA	NA	5443 / T	$852	$584
64450	Injection, other peripheral nerve or branch	$42	NA	$76	5442 / T	$644	$47
64486	Transversus abdominis plane (TAP) block unilateral; by injection(s) (includes imaging guidance, when performed)	$55	NA	$114	N	Pkgd	Pkgd
64510	Injection, anesthetic agent; stellate ganglion	$77	NA	$148	5443 / T	$852	$444
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection), imaging supervision and interpretation	$30	$28	$59	N	Pkgd	Pkgd
14	**SURGICAL**						
10005	Fine needle aspiration biopsy; including ultrasound guidance; first lesion	$74	NA	$138	5071 / T	$649	$338
+10006	; each additional lesion	$50	NA	$61	N	Pkgd	Pkgd
76932	Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation	$36	$0	$0	N	Pkgd	Pkgd
76936	Ultrasound guided compression repair of arterial pseudo aneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)	$94	$169	$263	5772 / S	$280	$146
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	$100	$0	$0	N	Pkgd	Pkgd
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection), imaging supervision and interpretation	$30	$28	$59	N	Pkgd	Pkgd
76998	Ultrasonic guidance, intraoperative	$61	$0	$0	N	Pkgd	Pkgd

VASCULAR - VENOUS ACCESS

Code[5]	Descriptor	2023 Physician Payment[6,7]			Hospital Outpatient[8]		ASC[9]
		Professional	Technical	Global	APC/ Status[10]	2023 Payment	2023
15	**VASCULAR**						
93882	Duplex scan of extracranial arteries; unilateral or limited study	$24	$102	$126	5522 / S	$107	Not payable
93926	Duplex scan of lower extremity arteries or arterial bypass grafts, unilateral or limited study	$23	$122	$145	5522 / S	$107	
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	$23	$102	$125	5522 / S	$107	
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	$21	$100	$121	5522 / S	$107	
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; limited study	$38	$123	$161	5522 / S	$107	
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	$23	$96	$119	5522 / Q1	$107	
93981	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	$21	$50	$71	5522 / S	$107	
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	$23	$125	$149	5522 / Q1	$107	
16	**VENOUS ACCESS**						
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	$84	NA	$192	5183 / J1	$2,979	$1,444
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	$84	NA	$217	5183 / J1	$2,979	$1,444
36557	Insertion of tunneled centrally inserted central venous catheter, w/out subcutaneous port or pump; younger than 5	$323	NA	$1,187	5184 / J1	$5,140	$2,641
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	$387	NA	$1,266	5183 / J1	$2,979	$1,444
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	$332	NA	$1,005	5183 / J1	$2,979	$1,444
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	$366	NA	$1,152	5184 / J1	$5,140	$4,583
36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	$357	NA	$4,351	5184 / J1	$5,140	$2,641
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age	$335	NA	$1,493	5183 / J1	$2,979	$1,444
36571	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older	$313	NA	$1,290	5183 / J1	$2,979	$1,444
36572	Insertion of PICC, without subcutaneous port or pump, including all imaging guidance, image documentation, and associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age	$81	NA	$383	5181 / T	$579	$301
36573	Insertion of PICC, w/o subcutaneous port or pump, inc all imaging guidance,documentation, radiological supervision and interp to perform the insertion; age 5 years or older	$84	NA	$392	5182 / J1	$1,488	$583
+76937	Ultrasonic guidance for vascular access requiring ultrasound eval of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, w perm recording and reporting	$14	$26	$40	N	Pkgd	Pkgd

References and endnotes

Questions

Contact Philips Reimbursement Resource Center

Email: IGTDReimbursement@philips.com

Endnotes

[1] www.ncbi.nlm.nih.gov/pmc/articles/PMC6360013/

[2] The Society of Point of Care Ultrasound (SPOCUS). SPOCUS Reimbursement Statement. https://spocus.org/admin-resources/billing-statement/

[3] Current Procedural Terminology CPT 2023 Professional Edition. American Medical Association.

[4] https://acphospitalist.org/archives/2020/03/coding-corner-point-of-care-ultrasound-part-1.htm

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[6] 2023 Medicare Physician Fee Schedule as outlined in CMS CY2023 Medicare Physician Fee Schedule, Addendum B, Final MPFS 2023 conversion factor 33.8872.

[7] Physician procedures performed in the hospital or ASC setting are reimbursed at the Medicare Physician Facility rate; procedures performed in the physician office setting are reimbursement at the Medicare Non-Facility rate or Global payment rate.

[8] Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2023 Final Rule, Addendum B

[9] Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2023 Final Rule, ASC Final Addenda.

[10] Medicare APC Status Indicators: J1: Comprehensive APC – accounts for all costs and component services typically involved in the provision of the complete primary procedure; Status N: No separate APC payment. Packaged into payment for other services; Status Q2: T-Packaged Codes - Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “T” or “J1”. In other circumstances, payment is made through a separate APC Payment.

[11] https://www.bcbsnm.com/pdf/cpcp030.pdf

[12] https://www.acep.org/administration/reimbursement/reimbursement-faqs/ultrasound-faqs#question3

[13] Malik AN, Rowland J, Haber BD, Thom S, Jackson B, Volk B, Ehrman RR. The Use of Handheld Ultrasound Devices in Emergency Medicine. Curr Emerg Hosp Med Rep. 2021 May 11:1-9. doi: 10.1007 s40138-021-00229-6. Epub ahead of print. PMID: 33996272; PMCID: PMC8112245.

[14] American College of Emergency Physicians. Appropriate use criteria for handheld pocket ultrasound devices: ACEP Policy Statement. Published July 2018.

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